MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

FILED AUG 19 1941

26488
Do not use this space.

1. PLACE OF DEATH
(a) County Worth — Registration District No. 905
(b) Township Allen — Primary Registration District No. 6216 — Registered No.
(c) City or — (d) Street No. — St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Rachel Seat
(a) Residence, No. — St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	White	Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF William Seat

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) October 2, 1852

7. AGE — YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
88	8	12	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Perry County, Ill.

FATHER
13. NAME Samuel R. Clark
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

MOTHER
15. MAIDEN NAME Elizabeth Ramsey
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

17. INFORMANT (ADDRESS) George A. Seat, Allendale, Ill.

18. BURIAL, CREMATION, OR REMOVAL — PLACE New Hope — DATE June 15, 1941

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Brack Bros, Denver, Ill.

20. FILED Aug 16, 1941 — C. L. Berry, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 14, 1941

22. I HEREBY CERTIFY That I attended deceased from June 4, 1941, to ....., 19.... I last saw h.er alive on June 14, 1941. Death is said to have occurred on the date stated above, at 4-A m.
The principal cause of death and related causes of importance were as follows:

Senile Debility — Date of onset

Other contributory causes of importance: 162P

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) [illegible] M. D.
(Address) [illegible]

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

S. No. 2B
M—8-21-41
I X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26488

Registration District No. 905 — Primary Registration District No. 6216 — Registrar's No.

1. PLACE OF DEATH:
(a) County: Worth
(b) City or town: Allen
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: (Specify whether
In this community: years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Worth
(c) City or town: Denver Mo
(If outside city or town limits, write "RURAL")
(d) Street No.: Rural
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Rachel Seals

3. (b) If veteran, name war:
3. (c) Social Security No.:

4. Sex: F | 5. Color or race: W | 6. (a) Single, widowed, married, divorced: wid

6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day: hr. min.

9. Birthplace: (City, town, or county) (State or foreign country)
10. Usual occupation:
11. Industry or business:

MOTHER
12. Name:
13. Birthplace: (City, town, or county) (State or foreign country)

FATHER
14. Maiden name:
15. Birthplace: (City, town, or county) (State or foreign country)

16. (a) Informant:
(b) Address:
17. (a) (Burial, cremation, or removal) (b) Date thereof: (Month) (Day) (Year)
(c) Place: burial or cremation:
18. (a) Signature of funeral director:
(b) Address:
19. (a) Oct 16 '41 (b) A L Perry
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: January Day: 14
year: hour: minute: M.

21. I hereby certify that I attended the deceased from: 19 to 19; that I last saw h[illegible] alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death:	
Due to:	
Due to:	
Other conditions: (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify):
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: (M. D. or other)
Address: Date signed:

SUPPLEMENTARY